Office-Supreme Court, U.S.
FILED
AUG 5 1981
STEVAS,
CLERK

No. 80-419

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

STATE OF ARIZONA, *Petitioner,*

v.

MARICOPA COUNTY MEDICAL SOCIETY, MARICOPA FOUNDATION FOR MEDICAL CARE, and PIMA FOUNDATION FOR MEDICAL CARE, *Respondents.*

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF FOR AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE AS *AMICUS CURIAE*

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RESTATEMENT OF QUESTION PRESENTED

Whether a maximum payment schedule developed by a foundation for medical care in connection with a contractual arrangement with an insurance company is *per se* legal under Section 1 of the Sherman Act.

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BRIEF FOR AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE AS *AMICUS CURIAE*[1]

STATEMENT OF INTEREST

The American Association of Foundations for Medical Care (AAFMC) is the national trade association of foundations for medical care (FMCs or foundations). Presently, thirty-two foundations are active members of AAFMC, including the respondent, Maricopa Founda-

[1] Petitioner and respondents have consented to the appearance of American Association of Foundations for Medical Care as *Amicus Curiae* in this case. Copies of the letters of consent have been filed with the Clerk of the Court.

tion for Medical Care. Five other foundations are associate members.

As the national association, AAFMC is interested in promoting foundation-sponsored health plans offered by health insurance companies. These plans effectively control health care costs through a variety of related activities. Maximum payment schedules, which are adopted by insurers under their arrangements with FMCs, form an integral part of these plans. Indeed, maximum payment schedules are an essential element in foundations' efforts to contain the costs of health care.

AAFMC's interest in this case is to promote flexibility in the manner in which its member foundations will be permitted to operate. In this connection, AAFMC has a complete understanding of FMCs' current operations.

This case goes to the heart of the operations of AAFMC's member foundations. If this Court holds that maximum payment schedules are *per se* illegal the impact on AAFMC's members will be devastating, and an effective cost containment mechanism will be lost.

AAFMC submits that the rule of reason is the correct method for analyzing maximum payment schedules developed by FMC's in conjunction with insurers or self-insurance plans. Application of the rule of reason will provide the courts with the flexibility to strike down anticompetitive practices when they occur, yet permit the maximum payment schedules operating in the public interest.

SUMMARY OF ARGUMENT

Per se analysis may only be applied to "naked restraints" falling within section 1 of the Sherman Act[2] which have no possible justification. In order to determine whether the *per se* rule should apply, the Court must undertake a threshold examination into the nature of the restraint, its purpose and effect, as well as the nature of the industry. Examination of these factors in connection with maximum payment schedules reveals that such schedules are not properly characterized as "price fixing" by competitors.

The actions of an FMC in conjunction with an insurer cannot be attributed to the participating physicians of the FMC without additional evidence. This must be determined on a case-by-case basis. Morever, a maximum payment schedule does not fix prices. Under this schedule, physicians are free to set any price they choose for their services. They are merely constrained from receiving payment in excess of the maximum from an insurer contracting with the FMC. Indeed, the FMC has no power to fix prices. Only the insurer has the power to enforce the maximum payment. Finally, the maximum payment schedule is permissible under the antitrust laws because it is necessary in order to enable an insurer to offer an FMC-sponsored health benefits plan.

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[2] 15 U.S.C. §1 (1976)

FACTUAL BACKBGROUND

I. COMPETITION IN THE PHYSICIAN SERVICES MARKET

A. The Market For Physician Services Is Unique And Not Well Understood.

If we have learned anything from the comments of economists and other scholars who have studied competition in the physician's services market, it is that competition in that market is qualitatively different from competition in many other markets, and that the variety of factors impacting upon the market are not well understood.[3] Economists are only now beginning to study the interrelationships among the factors that make competition in the physician services market unique. Although it is becoming clear that certain factors present in other competitive markets impact on the market for physician services, it is also clear that presence of certain factors, such as third party insurance, complicate the analysis.[4] In order for this Court to render an informed decision in this case, it must take notice of certain basic factors in the market within which any allegedly anti-competitive restraints operate.[5]

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[3] *See generally,* Competition in the Health Care Sector: Past, Present and Future (W. Greenberg ed. 1978) (proceedings of a conference sponsored by the FTC Bureau of Economics).

[4] *See, e.g.,* J. Newhouse, *The Structure of Health Insurance and the Erosion of Competition in the Medical Marketplace,* in *id.* at 270.

[5] The brief synopsis outlined herein presents the market as it exists. It has been argued that, as there is no competition in the physician services market, by definition, there can be no reduction.

The State of Ohio, in its Brief *Amicus Curiae*, points out certain factors which create "perverse incentives" for physicians to raise

Competition in the physician services market is atypical. Ordinarily, a consumer in the marketplace is presented with a choice of products of varying quality and at varying prices. The economic choice such a consumer must make involves a trade-off between quality and cost. In the market for physician services, however, the choice facing the consumer may be somewhat different. Although an uninsured patient who pays for services out of pocket on a fee-for-service basis faces economic choices similar to those in any normal business market, the insured consumer[6] is directly concerned only with the quality of services and is only indirectly concerned with their price.[7]

It is clear that the patient's range of choice of physicians may be restricted by the market. In many cases, particularly those which involve acute care, a patient does not exercise choice among physicians. In such a case, a patient must often accept the physician on call at the hospital. Further, once care is initiated by a physician, the patient often has no choice regarding which services are performed, which supplies are purchased, or

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prices. Brief for the State of Ohio as *Amicus Curiae*, at 3-6. Yet, it is clear that the interest of the State of Ohio is to revamp completely the nature of competition in the market. *Id.* at 7-9. That purpose is essentially irrelevant to the issue at hand which is whether the maximum payment schedule is an illegal restraint of trade.

[6] As this case involves FMCs which deal only with insured patients, they are the relevant consumers for purposes of analysis.

[7] Consumers whose health insurance is entirely paid for by their employers have no concern for physicians' prices to the extent that the insurer pays the entire amount of the physician's fee. They may, however, be indirectly concerned with physicians' fees to the extent that they relate to the cost of health insurance which is the subject of a collective bargaining agreement.

which specialists are consulted. Moreover, some insurers place maximum limitations on payment for services. This limitation, however, means only that the differential is paid directly by the patient.

Insurance companies often do consider price. However, here, as well, market forces operate differently from those of the normal business market. As the insurer does not itself receive the services, it is necessarily less directly concerned with quality than the ordinary consumer. Moreover, many insurers have, in effect, taken themselves out of the market with regard to quality by accepting the principle of freedom of choice.[8]

In contrast to the market for physician services, the market for health insurance involves both quality and price. Yet, here as well, the incentives are vastly different from those in a typical market. To the extent that health insurance is an employee benefit, price may be removed as a consideration of an employee in choosing a benefits plan.[9] Even if an employee shares the cost of health insurance, price competition among insurers for enrollees is minimized, because the actual cost of any package is greater than the price directly faced by the employee. Moreover, competition over quality in this market relates to comprehensiveness of the services covered and reliability of the plan as well as to quality of services offered by a plan's physicians. Indeed, in plans permitting freedom of choice, quality of services is not a major factor because the consumer may choose any primary care physician.

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[8] The notable exception of health maintenance organizations (HMOs) is discussed *infra* at pages 8, 19.

[9] Price may be a factor to the extent a patient may be billed by a physician for the excess over covered charges.

B. The Role Of Foundations For Medical Care.

Since their inception in the 1950's, FMCs have played an important role in controlling the cost and improving the quality of medical care provided to consumers through third party insurers.[10] The stimulus responsible for the initial development of FMCs was dissatisfaction with existing forms of health insurance. Typically, benefits packages operated on an indemnity basis and generally were not comprehensive. Payment for many services was dependent upon hospitalization, thereby encouraging unnecessary hospitalization and increasing the cost of health care. Faced with the difficult choice of providing services on an uncovered basis or unnecessarily hospitalizing a patient to ensure coverage, some physicians responded by urging the creation of more appropriate benefits packages which would protect the patient by holding down costs and insuring appropriateness of care.

These physicians organized FMCs to contract with insurers to provide care to patients.[11] Early in their history, FMCs recognized that the prevailing use of the "usual and customary" fees dramatically increased costs to insurers, and, more importantly, to patients. Thus, the maximum payment schedule was born as an additional significant means of controlling costs. These schedules, which are typically set substantially below usual and customary fees, were combined with agreements which required the participating physician to ac-

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[10] *See generally* R. Egdahl, *Foundations for Medical Care,* 288 New Eng. J. Med. 491 (1973).

[11] There is a second type of FMC which provides only peer review services. However, the concern here is solely with those that provide care on a contractual basis with insurers.

cept payment from the contracting insurer as payment in full for services rendered. As a result, the patient was protected against any requirement for payment of fees above the schedule.

Subsequently, as data regarding care and utilization grew, FMCs also initiated peer review programs to review the quality and appropriateness of care provided. These programs had the added benefit of reducing costs, for they foreclosed payment for unnecessary services. Additionally, some FMCs began to process claims for their contracting insurance companies.

A more recent development in the history of the health care industry has been the appearance of health maintenance organizations. HMOs, many of which have their roots in FMCs,[12] developed when some physicians decided to limit the participation of third party insurers. In an HMO setting, the physicians themselves underwrite a large portion of the risk, contracting out only exceptional risks.

ARGUMENT

I. DETERMINATION OF THE PROPER METHOD OF ANALYSIS REQUIRES REVIEW OF THE NATURE OF THE ACTIVITY WITHIN THE CONTEXT OF THE HEALTH INDUSTRY AS WELL AS POTENTIAL JUSTIFICATIONS FOR THAT ACTIVITY

In order to determine whether a maximum payment schedule should be classified as a *per se* violation, or whether it requires analysis under the rule of reason, the Court must undertake an inquiry into the nature of the

[12] Indeed, the San Joaquin Foundation, a prototype foundation, was also identified as a model for the federal Health Maintenance Organization Act of 1973 as amended, 42 U.S.C. 300e *et seq.* (1976 & Supp. III 1979).

alleged restraint and its potential justifications. As Mr. Justice Brandeis stated in *Board of Trade* v. *United States*:

> The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the Court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be obtained, are all relevant facts. This is not because a good intention will save an otherwise objectionable regulation but because knowledge of intent may help the court to interpret facts and to predict consequences.

246 U.S. 231, 238 (1918).

At first, all restraints of trade were analyzed under the "rule of reason" structure outlined by Mr. Justice Brandeis and others. However, as the Court discovered that certain kinds of agreements were so manifestly anticompetitive that there was no possible justification for their existence, *per se* categories began to develop. *See, e.g., Northern Pacific Railroad* v. *United States*, 356 U.S. 1 (1958) (tying arrangement); *United States* v. *Trenton Potteries Co.*, 273 U.S. 392 (1927) (price fixing) (*Trenton Potteries*); *United States* v. *Addyston Pipe & Steel Co.*, 85 F. 271 (6th Cir. 1898), *aff'd as modified*, 175 U.S. 211 (1899) (market allocation) (*Addyston Pipe & Steel*). The *per se* rules thus reflect the judgment that, within these categories of naked restraints, cases which do not fit the general rule "are not sufficiently common or important to justify the time and expense necessary to

identify them." *Continental T.V., Inc.* v. *GTE Sylvania, Inc.* 433 U.S. 36, 50 n.16 (1977) (*Continental T.V.*).

When a court encounters a particular restraint, it should make a threshold two-fold inquiry to determine whether *per se* or rule of reason analysis should be applied. First, it should identify the nature of the restraint and the industry in which it operates to determine whether it is identical to other restraints which have been characterized as *per se* offenses. If the court concludes that it is not, it should next review the justifications offered in defense of the challenged restraint.

In particular, the Court should review the purpose and history of the restraint, its effect on the industry, and whether the restraint is pro-competitive in any way. *See Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1, 99 S. Ct. 1551 (1979) (*Broadcast Music*). If, upon this review, the court determines that the restraint has no possible justification it should be condemned as *per se* illegal without further analysis. *See National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 680 (1978) (*Engineers*)[13]; On the other hand, if the Court finds the existence of potential justifications, the restraint should be analyzed under the rule of reason. *See Broadcast Music*, 99 S. Ct. at 1565. In *Broadcast Music*, for example, this Court found that rule of reason analysis was appropriate (even though the arrangement literally "fixed" a price) because of the existence of several justifications.

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[13] In *Engineers*, the Court found that there was no possible justification for the total ban on competitive bidding effected by the society's rules.

Many lower courts have held that the *per se* rules are not applicable at all when the peculiar characteristics of an industry necessitate certain anti-competitive behavior. *E.g., Mackey* v. *National Football League*, 543 F.2d 606, 619 (8th Cir. 1976), *cert. dismissed*, 434 U.S. 801 (1977). AAFMC submits that market conditions in the health care industry are sufficiently peculiar, and that exceptions to any general rule are sufficiently common and important to outweigh any administrative advantages of the *per se* rule. Rule of reason analysis is also appropriate here, in view of the Court's lack of experience with the health care industry and with maximum payment schedules as applied in a professional rather than commercial setting.[14] *See Broadcast Music*, 99 S. Ct. at 1557; *Engineers*, 435 U.S. at 687-92; *Goldfarb* v. *Virginia State Bar*, 421 U.S. 733, 788-89 n.17 (1975) (*Goldfarb*). Indeed, courts have consistently found the rule of reason to be the appropriate method of dealing with the variety of situations which have arisen in the health care industry. *See e.g., Virginia Academy of Clinical Psychologists* v. *Blue Shield*, 624 F.2d 476, 485 (4th Cir. 1980) (*Virginia Academy*); *Sausalito Pharmacy, Inc.* v. *Blue Shield*, [1980-81] Trade Cas. (CCH) ¶ 63,695 at 77,724-25 (N.D. Cal. May 12, 1980); *United States* v. *American Society of Anesthesiologists*, 473 F. Supp. 147, 157 (S.D.N.Y. 1979).

[14] The State of Ohio apparently attempts to establish the requisite experience by reference to *United States* v. *American Medical Association*, 317 U.S. 519 (1943). Yet that case dealt only with a boycott and with the applicability of the labor exemption. The court was not required to consider the factors relating to competition in the market for physician services. Moreover, similar circumstances existed in *Broadcast Music*. The Justice Department had first investigated allegations of anticompetitive conduct fifty years prior to that decision, and a consent decree had been entered into 38 years before the decision.

II. ESTABLISHMENT OF A MAXIMUM PAYMENT SCHEDULE BY AN INSURER IN CONNECTION WITH AN FMC IS NOT A TRADITIONAL NAKED RESTRAINT

It can hardly be questioned that maximum payment schedules can be a legitimate and important element in a health insurance plan. What is at issue is whether a foundation can play a legitimate role in the establishment of such schedules. We submit that they can. FMCs are independent corporations with interests that are not necessarily coextensive with the individual interests of the physician membership. FMCs can provide insurers with useful information regarding existing physician fee and participation patterns which are important in establishing maximum payment rates.[15] Insurers are, of course, free to reject any maximum payment schedule developed and, indeed, to refrain from doing business with FMCs as they typically have no monopoly power.

A. The Maximum Payment Schedule Is Not Set By Competitors.

Without evidence to the contrary, the development of a maximum payment schedule by an FMC is not joint action by competitors, but merely the act of a corporate entity. It cannot constitute an antitrust violation, for a corporation cannot conspire with itself. *Nelson Radio & Supply Co.* v. *Motorola, Inc.*, 200 F.2d 911 (5th Cir. 1952), *cert. denied*, 345 U.S. 925 (1953). Moreover, an arrangement between an FMC and an insurer involving a maximum payment schedule is permissible as nothing more than an arms-length business arrangement.

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[15] While some insurers have the data base to perform these functions internally, others do not.

It is true, of course, that in some circumstances, the action of an FMC may be attributed to the joint action of its member physicians. *See Virginia Academy*, 624 F.2d at 479-81 (4th Cir. 1980). However, this must be determined as a factual matter on a case-by-case basis under the rule of reason. *See id.* at 481.

In this connection, it must be noted that the method of establishing the maximum payment schedule varies among FMCs. Some foundations grant member physicians voting rights regarding the establishment of the fee schedule. Other FMCs provide indirect methods of participation, such as polling. In other cases, rates are set by the Board of Directors, or a committee of the foundation without any participation by the membership. Typically, the maximum payment levels are not circulated to the membership. The impact of each of these types of participation and other factors must be weighed individually.

B. A Maximum Payment Schedule For Physician Services Is Not Price Fixing.

In those circumstances in which the Court has considered maximum pricing, it has been treated as if it were minimum pricing. *See Albrecht* v. *Herald Co.*, 390 U.S. 145 (1968) (*Albrecht*); *Kiefer-Stewart Co.* v. *Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951) (*Kiefer-Stewart*).[16] The rationale expressed for such identical

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[16] There is some question whether the *Albrecht* rule is correct. As Mr. Justice Harlan stated:

> Both practices [price ceilings and price floors] share the negative attribute that they restrict individual discretion in the pricing area, but only the former imposes upon the public the much more significant evil of lessened competition, and, as just seen, the latter has an important arguable justification [pre-

treatment was that agreements to fix maximum prices "no less than those to fix minimum prices . . . restrain their [the sellers'] ability to sell in accordance with their own judgment." *Kiefer-Stewart*, 340 U.S. at 213; *see also Albrecht*, 390 U.S. at 152. Additionally, identical treatment was justified because "if the actual price charged under a maximum price scheme is nearly always the maximum price . . . the scheme tends to acquire all the attributes of an arrangement fixing minimum prices." *Albrecht*, 390 U.S. at 154.

In order to constitute price fixing under *Kiefer-Stewart* and *Albrecht*, a maximum payment schedule must significantly interfere with the physician's ability to set his or her own rates. Yet, a physician who chooses to participate in an FMC-sponsored health plan agrees only that he will accept the maximum allowable fee as full payment for any particular service provided to a patient insured by the plan. The physician remains free to establish higher or lower rates for services in accordance with his "usual and customary" fees. Indeed, the physician may collect higher fees from other insurers or direct-pay patients. The only constraint upon the physician is that he may not collect more than the maximum amount from the FMC-sponsored insurer.

The rationale expressed in *Kiefer-Stewart* and *Albrecht* does not, therefore, apply to an FMC maximum payment schedule. Both *Kiefer-Stewart* and

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venting monopoly or supercompetitive profits] that the former does not possess. In a maximum price case the asserted justification must be met on its merits, and not by incantation of a *per se* rule developed for an altogether different situation.

390 U.S. at 159 (Harlan, J. dissenting); *see also* 390 U.S. at 168-70 (Stewart, J. dissenting). Several commentators have also taken issue with the rule established in *Albrecht*. *See* 10 B.C. Indus. & Com. L. Rev. 208, 215 (1969); 37 U. Cin. L. Rev. 411, 415-16 (1968).

Albrecht involved restraints imposed by a manufacturer on a distributor in a market that was amenable to price competion. In such a situation the manufacturer establishes both the cost of the product supplied and the maximum price for which the product may be sold by the distributor. Thus, the manufacturer would control the profit margin of the distributor. As the profit margin approaches zero, i.e., as the cost of the product approaches the maximum selling price, the maximum price would tend to become the actual price. As the court pointed out in *Albrecht,* under this circumstance the maximum price fixing mechanism acquires the attributes of an arrangement fixing minimum prices. 390 U.S. at 153.

Here, the considerations are different. The entities imposing maximum allowable payments do not control the profit margin because they do not control physician costs. There is, therefore, considerably more latitude for price differentials in this case than in *Albrecht* or *Kiefer-Stewart* because physicians' costs may be different. Moreover, maximum payment schedules are typically set substantially below the average usual and customary fees for physicians in the community. Indeed, by agreeing to participate in a foundation-sponsored health plan, the participating physician trades a reduction in charge for assurance of prompt payment in full. Finally, participating physicians do not always charge the maximum allowable price for services.[17] All of these factors, taken together, indicate that the establishment of a maximum payment schedule is far different from the establishment of a minimum price by competitors.

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[17] Evidence that all FMC physicians charge the maximum price would constitute evidence of a minimum price fixing scheme. This factual matter should be determined on a case-by-case-basis.

C. FMCs Do Not Have Sufficient Coercive Power To Enforce Prices.

The power to set prices requires the power to enforce them. *See United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. at 210 ("where the members of a combination had the power to raise prices . . ."); *Trenton Potteries*, 273 U.S. at 394 (control of substantial part of the industry).

Prices may be imposed vertically, as in *Continental T.V.*, where the resale price was imposed by the newspaper upon distributors, or they may be imposed horizontally as in *Trenton Potteries*, where competitors agreed to maintain a price. Professional associations have also imposed and enforced restraints upon price competition. *See Engineers*, 435 U.S. at 684 n.5 (ethical restrictions on competitive bidding); *Goldfarb*, 421 U.S. at 781-83 (adherence to minimum fee schedule subject to enforcement by disciplinary measures). Such restraints have both horizontal and vertical elements.

Unlike the professional society in *Engineers* or the bar association in *Goldfarb*, an FMC does not have the power to enforce adherence to the maximum payments schedule. An FMC is not a professional association. It does not possess the ethical authority or coercive ability of a bar association or a medical society. At most, an FMC has only the power to exclude a physician from participation in the plan, and it is unclear that such a threat is sufficiently coercive given the nature of the market.[18]

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[18] Many FMCs have strict limitations governing exclusion and expulsion of member physicians. Fee levels are ordinarily not among the acceptable reasons.

Perhaps the most important reason that FMCs do not have the power to enforce maximum payment schedules is the availability of options out of the system. *Compare Broadcast Music with Goldfarb.* Unlike the situation in *Goldfarb,* where state law required title searches to be conducted by attorneys, patients and insurers have options other than dealing with the FMC. Patients may purchase other indemnity plans, join an HMO or pay physicians directly. In fact, FMC plans typically represent only a small portion of the insured market. Moreover, a patient's choice of physician will not be affected, as FMCs do not have exclusive arrangements with participating physicians. In the absence of such an exclusive arrangement, insurers are also free to negotiate with individual physicians or with groups of physicians.

The availability of the options out of the system effectively precludes FMC from exercising sufficient market control to enforce the maximum payment schedule.[19] As in *Broadcast Music,* the consumers in the market for physician services "have a real choice." 99 S. Ct. at 1564. Because there is "no legal, practical or conspirational impediment to obtaining individual [contracts]," there is no price fixing scheme. *Id.; see also K-91, Inc.* v. *Gershwin Publishing Corp.,* 372 F.2d 1, 4 (9th Cir. 1967), *cert. denied,* 389 U.S. 1045 (1968).

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[19] Of course, if an FMC organized or participated in a boycott of an insurer by member physicians as a result of negotiations over fees, the FMC and its member physicians could be held liable for a concerted refusal to deal. *See In re Michigan Medical Society,* FTC Docket No. 9129 (June 22, 1981) (using rule of reason analysis). A similar result might obtain if the FMC established formal exclusive arrangements with a substantial number of participating physicians. There is no evidence in the record that the respondent foundations engaged in any such activity.

D. A Maximum Payment Schedule Is Necessary To The Offering Of A Health Benefits Package.

Courts have historically recognized that certain arrangements which may affect prices should not be analyzed under the price fixing rules. *See Addyston Pipe & Steel,* 85 F. at 281-82. This philosophy was recently affirmed by this Court in *Broadcast Music.* Per Mr. Justice White, writing for the majority:

> Mergers among competitors eliminate competition, including price competition, but they are not *per se* illegal and many of them withstand attack under any existing antitrust standard. Joint ventures and other cooperative arrangements are also not usually unlawful, at least not as price fixing schemes, *where the agreement in price is necessary to market the product at all.*

99 S. Ct. at 1564 (emphasis supplied).

An FMC-sponsored health plan is, in effect, a joint venture between the insurer and the FMC. The insurer obtains benefits from the joint venture in the form of the ability to advertise as an FMC-sponsored plan, and to receive the benefit of the services provided by the FMC. The FMC and its member physicians benefit by having a prompt and reliable source of payment for bills.

An FMC maximum payment schedule is a legitimate component of an FMC-sponsored health plan offered by an insurer. It enables the insurer to more accurately predict its maximum costs and set its premium rates accordingly,[20] as well as to contain costs.

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[20] In the absence of the maximum fee schedule, some other predictive mechanism would necessarily evolve. One option would be a return to the more inflationary usual, customary and reasonable rates.

This characterization is clearest when physicians accept a greater portion of the risk. The resulting HMO is most aptly characterized as a joint venture among the participating physicians. In this setting, the ability to predict costs accurately is essential to the ability to offer a benefit package and a maximum payment schedule should certainly be permitted. *See Addyston Pipe & Steel,* 85 F. at 281-82; Brief for the United States as *Amicus Curiae* on Petition for Writ of Certiorari at 10 n.9; Brief For The State of Ohio as *Amicus Curiae* at 22-23. However, many other types of FMC-insurer arrangements can be characterized as legitimate joint ventures as well. Courts should be free to examine the many different varieties on a case-by-case basis.

CONCLUSION

For the foregoing reasons, AAFMC, as *amicus curiae,* respectfully requests this Court to affirm the decision of the United States Court of Appeals for the Ninth Circuit.

Respectfully submitted,

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